CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
TABLE OF CONTENTS

	Page
Reimbursement Rates	1
Authorization	1
Medicaid Invoices for Private Duty Nursing and Respite Care	1
Submission of Billing Invoices	1
Electronic Submission of Claims	2
General Information	2
Timely Filing	2
Electronic Filing Requirements	4
ClaimCheck	5
Remittance/Payment Voucher	5
ANSI X12N 835 Health Care Claim Payment advice	6
Claim Inquiries	6
Replenishment of Billing Materials	6
Instructions for the Use of the CMS-1500 (12-90) Billing Form	8
Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice	13
Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice	14
Special Billing Instructions – Technology Assisted Waiver Services	15
Special Billing Instructions/Client Medical Management Program	17

EDI Billing (Electronic Claims) 17

Special Billing Instructions - Medallion 18

Invoice Processing 18

Turnaround Document Letter (TAD) 18

Patient Information Form (DMAS-122) 19

Purpose 19
Disposition of Copies 19

Exhibits 20

CHAPTER V
BILLING INSTRUCTIONS

REIMBURSEMENT RATES

The fee for private duty nursing is an hourly fee reimbursed for time the nurse actually provided the service. This fee must cover all expenses associated with the delivery of nursing services including supervisory visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider agency incurs. The current rates for private duty nursing services to Home- and Community-Based Care Waiver individuals are set forth later in this manual.

AUTHORIZATION

The Health Care Coordinator shall document the amount of nursing or respite care needed in the individual's Plan of Care. Services are certified as medically necessary by the signatures on the initial assessment of the physician and other members of the multi-disciplinary screening team. DMAS approval prior to implementation is necessary for Tech Waiver/EPSDT Nursing services. Upon completion, the Health Care Coordinator or Case Manager shall send a copy of the authorization package to the nursing and respite care provider.

MEDICAID INVOICES FOR PRIVATE DUTY NURSING AND RESPITE CARE

Providers must use the CMS-1500 (12-90) to bill for private duty nursing.

Submission of Billing Invoices

Nursing providers are instructed to submit claims using the actual dates of service rendered within a calendar month. Invoices must include only allowable charges for the number of hours for services rendered during the calendar month. Any charges submitted prior to the date authorized by the Health Care Coordinator or Case Manager as the begin date will be rejected. Invoices and adjustments must be submitted in the green-edged, self-addressed envelope provided by DMAS. The provider copy must be retained by the provider for record keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to DMAS' address; this will only delay processing. Provider agencies should allow at least three to four weeks for claims processing.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (888) 829-5373 and choose Option 2 (EDI)
Fax number: (804)-273-6797
First Health's. website: http://virginia.fhsc.com., or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

GENERAL INFORMATION

Timely Filing

DMAS regulations require the prompt submission of all claims. Federal regulations require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a dated letter from the local department of social services (DSS) which specifies: that the delay has

occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

- Denied Claims - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) invoice as explained under the Instructions for the Use of the CMS-1500 (12-90) Billing Form on page 8 of this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely fillings being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

  - Indicate unusual service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

  - Submit the claim by mailing the claim to:

    Department of Medical Assistance Services, Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

- Submit an original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from

the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

There is no Medicare coverage of MR Waiver services. Therefore, no claims should be sent to Medicare intermediaries for MR Waiver services provided.

IMPORTANT: When billing on the CMS-1500 (12-90), Virginia Medicaid will only accept an original form printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Additionally, only the CMS-1500 (12-90) form will be accepted; previous editions or other versions of this form will not be accepted.

The requirement to submit claims on an original CMS-1500 (12-90) form is necessary because the individual signing the invoice is attesting to the statements on the reverse side, and, therefore, these statements become part of the original billing invoice.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003 will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (888)-829-5373 and choose Option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms, which can be downloaded, from the DMAS web site (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500 (12-90). **The required fields to be completed are printed in boldface.** Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found later in this chapter.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), Billing Invoice

The purpose of the CMS-1500 (12-90) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees. (See "**Exhibits**" at the end of the chapter for a sample of the form).

Locator Instructions

Locator		**Instructions**
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the enrollee receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the enrollee receiving the service.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name

Locator		Instructions
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT Required.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**CONDITIONAL**	**CLIA #**
20	NOT REQUIRED	Outside Lab?
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the**

Locator		Instructions
		appropriate ICD-9-CM diagnosis, which describes the nature of the illness or injury for which the service was rendered.
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	**CONDITIONAL**	**Prior Authorization Number – Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a 2-digit format for the month and day (e.g., 04/01/98). DATES MUST BE WITHIN THE SAME YEAR.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit national place of service code, which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit national code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code, which describes the procedure rendered, or the service provided. See the attached code list for special instructions if appropriate for your service.** **Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable. When billing procedure codes 99281-99285, enter values of 1, 2, 3, and 4 only. The numbers are intended to relate the procedures back to the ICD-9-CM diagnosis code in Locator 21. The CMS-1500 (12-90) can accommodate up to four ICD-9-CM diagnosis codes in Locator 21. Claims with values other than 1, 2, 3, or 4 in Locator 24-E may be denied. Must be values 1, 2, 3 or 4 only.**

Locator		Instructions
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	**CONDITIONAL**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**CONDITIONAL**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage. All claims submitted with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following:** • **The Explanation of Benefits (EOB) from the primary carrier; or** • **A statement from the primary carrier that there is no coverage for this service; or** • **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or** • **A statement from the provider indicating that the primary insurance has been canceled.**

Locator		Instructions
		Claims with no attachment will be denied.
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number – Up to seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
	REQUIRED	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address, ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code. Enter Group# (billing provider number) if applicable.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22

Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong enrollee eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Enrollee not my patient
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

SPECIAL BILLING INSTRUCTIONS – TECHNOLOGY ASSISTED WAIVER SERVICES

Locator 24D Procedures, Services, or Supplies

CPT - Enter the appropriate code from the following list.

Local Code[1]	National Code[1]	Modifier	Description	Rate (for dates of service on or after July 1, 2003)
Z9401	T1002		Private Duty Nursing/RN	
			Northern Virginia	$ 30.00
			Rest of State	24.70
Z9402	T1003		Private Duty Nursing/LPN	
			Northern Virginia	26.00
			Rest of State	21.45
Z9403	S9125	TD	Respite/RN	
			Northern Virginia	30.00
			Rest of State	24.70
Z9404	S9125	TE	Respite/LPN	
			Northern Virginia	26.00
			Rest of State	21.45
Z9405	T1030		Congregate/RN	
			Northern Virginia	20.00
			Rest of State	17.35
Z9406	T1031		Congregate/LPN	
			Northern Virginia	18.00
			Rest of State	15.73
Z9407	T1030	TD	Congregate Respite/RN	
			Northern Virginia	20.00
			Rest of State	17.35
Z9408	T1031	TE	Congregate Respire/LPN	
			Northern Virginia	18.00
			Rest of State	15.73
Z4037	S9122		Congregate Aide (Adults Only)	
			Northern Virginia	10.45
			Rest of State	9.14
Z9425	S9125		Congregate Respite Aide (Adults Only)	
			Northern Virginia	10.35
			Rest of State	9.05

[1] Providers may begin using the national billing codes for dates of service on or after June 20, 2003. For dates of service after December 31, 2003, national billing codes must be used. Local/national code crosswalk is available on the DMAS website.

Z8599	N/A		(Environmental Modification, Rehab. Engineer)	
Z8600	S5165		Environmental Modification Only	Individual Consideration (IC)
Z8601	N/A		(Environmental Modification, Supply Only)	
Z8602	N/A		(Environmental Modification, Transportation Mod.)	
Y0058	99199	U4	Environmental Modification, Maintenance Costs Only	IC
Z8603	N/A		(Assistive Technology, Rehab. Engineer)	
Z8604	T1999		Assistive Technology Only	IC
Z8605	T1999	U5	Assistive Technology, Maintenance Costs Only	IC
Z9490	G0238		Personal Care by Respiratory Therapist	
			Northern Virginia	18.18
			Rest of State	15.15
Z9489	T1019		Aide (Adults Only)	
			Northern Virginia	13.38
			Rest of State	11.36

Locator 24E **Diagnosis Code - Enter the appropriate code from the following list.**

Code	Description
V46	**Ventilator dependent patients**
2791	**Immune mechanism disorder**

Enter the diagnosis code specific to the recipient's diagnosis if the individual is neither ventilator dependent nor HIV+/AIDS.

Locator 24J **COB (Primary Carrier Information)**

3 - Billed and Paid (Use for patient pay.)

Locator 24K **Reserved for Local Use**

Enter the patient pay amount if applicable

SPECIAL BILLING INSTRUCTIONS/CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician treating a restricted recipient as a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17A and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10D.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

SPECIAL BILLING INSTRUCTIONS - MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the *Physician Manual* issued by DMAS.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PC in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

Turnaround Document Letter (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to FHS. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

PATIENT INFORMATION FORM (DMAS-122)

Purpose

This form is used by local Departments of Social Services (DSS) and Medicaid providers to exchange information with respect to:

- Responsibility of an eligible client to make payment toward the cost of care;
- Admission, discharge, or death of the client; or
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the Health Care Coordinator or Case Manager to request a Medicaid number, eligibility determination, or confirmation of patient pay or to notify the local DSS of changes in the client's circumstances. A new form is to be prepared by the local DSS at the time of each redetermination of eligibility and whenever there is any change in the client's circumstances that results in a change in the amount of patient pay.

Disposition of Copies

The Health Care Coordinator or Case Manager will initiate the form in order to notify the local DSS that the individual has been admitted to the program and to provide the beginning date of service. Upon determination of eligibility, the DMAS-122 will be returned to the Health Care Coordinator or Case Manager with the following information:

- Whether the client does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient ‘pay responsibility’ begins.

The Health Care Coordinator or Case Manager is responsible for sending a copy of the DMAS-122 to the Private Duty Nursing provider(s) to inform the provider of the patient pay amount. The Private Duty Nursing provider should have a completed DMAS-122 form in the client's file prior to billing DMAS.

The Private Duty Nursing provider should not generate the DMAS-122 but should obtain a copy for his or her files from the Health Care Coordinator or Case Manager.

EXHIBITS

TABLE OF CONTENTS **Page**

Health Insurance Claim Form CMS-1500 1

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ — PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM MM | DD | YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM MM | DD | YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)